MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00662

Item 16, Film G-238 1/29/59.cac.

Reg. Dist. No. 696

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
BM 2/57

1. PLACE OF DEATH — a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Monkton RD
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 146 Near Taylor

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xShawsville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle Leroy Last Adams Jr
4. DATE OF DEATH: Month January Day 24 Year 1959

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: aug 2 1929
9. AGE (In years last birthday): 29 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Station Operato
10b. KIND OF BUSINESS OR INDUSTRY: St Chair Gas Products
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John LeRoy Adams
14. MOTHER'S MAIDEN NAME: Nola Ray Openhaver
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service: NO
16. SOCIAL SECURITY NO.: 213-28-8820
17. INFORMANT — Address: Mrs Nola R. Adams White Hall Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH:
.819x
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident Auto-object
20c. TIME OF INJURY — Hour 2 a. m. p.m. — Month, Day, Year 1-24 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 146
20f. (City or town) Monkton (County) Harford (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D. — Bel Air, Md — DATE SIGNED: 1-24-59
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Gerald C Palmer M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan 27-59
22c. NAME OF CEMETERY OR CREMATORY: Bethel
22d. LOCATION (City, town, or county) (State): Madonna Harford Md

23. FUNERAL DIRECTOR'S SIGNATURE: Martin S Knuck — ADDRESS: Jane Townhead Md
24a. REC'D BY REGISTRAR — DATE: JAN 29 '59
24b. REGISTRAR'S SIGNATURE: Clifford L. Keene

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0666

678

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY: Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air

LENGTH OF STAY (in this place): 6 Mo.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: ~~Harford Convalisceing Home~~ ~~Bel Air, Md.~~

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Norrisville

STREET ADDRESS (If rural give location): White Hall RD

3. NAME OF DECEASED (Type or Print): (First) Luella (Middle) E. (Last) Almony

4. DATE OF DEATH: (Month) Jan. (Day) 3 (Year) 1959

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed	Nov. 1865	93 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Harford Co. Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas J. Ayres	Alice Norris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	— — —	-----	Arnold Ayres Fawn Grove, Pa.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1(a) IMMEDIATE CAUSE (A)	Hypostatic Pneumonia	6 Mo.
ANTECEDENT CAUSE(S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B)	Chronic Cardio Vascular Disease	?
DUE TO (C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1958, to Jan. 2, 1959, that I last saw the deceased alive on Jan. 2, 1959, and that death occurred at 11:30 P.M. from the causes and on the date stated above.

SIGNATURE: Willard P Hudson M.D. ADDRESS (Street, city, town, state): Forest Hill, Md. DATE SIGNED: Jan. 5, 1959

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/6/1959	Ayres Chapel	White Hall RD Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
JAN 7 '59	Arthur L. Harris	Charles E. Kurtz	Jarrettsville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

671 CERTIFICATE OF DEATH

00664

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre-de-Grace
c. LENGTH OF STAY IN 1b D.O.A.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville
d. STREET ADDRESS 1 Aiken Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First R. Middle Luke (Luca) Last Amato.
4. DATE OF DEATH Month 1 Day 2 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 7-1-1907
9. AGE (In years last birthday) 51 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman
10b. KIND OF BUSINESS OR INDUSTRY Sisk-Co.
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Leonard Amato
14. MOTHER'S MAIDEN NAME Elizabeth Alagia

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-14-8090
17. INFORMANT Address Rita Amato, Perryville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 20 minutes
DUE TO (b) Coronary Thrombosis — 1 wk.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-26 19 58 to 1-2 19 59 that I last saw the deceased alive on 1-2 19 58, and that death occurred at 10:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE [signature] M.D. ADDRESS (Street, city or town, state) Perryville, Md DATE SIGNED 1-2-59

PHYSICIAN'S NAME (Type) G.H. Richards Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1-5-1959
22c. NAME OF CEMETERY OR CREMATORY Mt. Erin Cemetery
22d. LOCATION (City, town, or county) (State) Havre De Grace, Md

23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Sons ADDRESS Perryville, Md
24a. REC'D BY REGISTRAR DATE JAN 6 '59
24b. REGISTRAR'S SIGNATURE Carlton S. Knaub

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1D

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00665 Reg. Dist. No.

672

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Jarrettsville
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN Middle W. Last AMREIN

4. DATE OF DEATH: Month January Day 8 Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: June 15, 1908

9. AGE (In years last birthday): 50 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Harford County

11. BIRTHPLACE (State or foreign country): Jarrettsville Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles H. Amrein

14. MOTHER'S MAIDEN NAME: Mary A. Eicholtz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: 213-20-5968

17. INFORMANT: Henrey Amrein Address: Forest Hill, Md.

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct
420.1
DUE TO: Coronary Sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Russell S Fisher M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 1/8/59

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/10/59
22c. NAME OF CEMETERY OR CREMATORY: Wm. Watters
22d. LOCATION (City, town, or county) (State): Cooptown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles C. Kurtz ADDRESS: Jarrettsville Md.

24a. REC'D BY REGISTRAR DATE: JAN 12 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please state the cause, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be recorded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

697 — 00666 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air, R.D.,
c. LENGTH OF STAY IN 1b: 7 mos.,
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Convalescing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bradshaw 03X-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry — Middle: S. — Last: Bartkowiak

4. DATE OF DEATH: Month: Jan. — Day: 31, — Year: 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct.16,1880

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Tenant

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-30-2272

17. INFORMANT: Mrs. Geo., A. Kahl — Address: Fullerton, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrompos is. — INTERVAL BETWEEN ONSET AND DEATH: 10 min.
DUE TO (b): Arteriosclerotic Heart Disease — 12 yrs.
DUE TO (c):
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 3, 1958 to Jan 31, 1959 that I last saw the deceased alive on Jan 30, 1959 and that death occurred at 4:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clifford F. Hudson M.D. — ADDRESS (Street, city or town, state): Fork Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): CLIFFORD F. HUDSON FORK MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb.4,1959

22c. NAME OF CEMETERY OR CREMATORY: St. Stephens

22d. LOCATION (City, town, or county) (State): Bradshaw, Balto., Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K McCormick — ADDRESS: Abingdon, Maryland.

24a. REC'D BY REGISTRAR — DATE: FEB 5 '59

24b. REGISTRAR'S SIGNATURE: Cathryn S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Harford | Maryland | Baltimore

Bel Air, R.D., ; 7 mos., Broadway

Harford Convalescing Home

Henry B. Bartkowiak Jan. 31, 59

male white Married Oct.15,1880 78

Farmer Tenant Poland U.S.A.,

Unknown Unknown

no 220-20-2277 Mrs. Geo., A. Kehl Fullerton,Maryland.

Burial Feb.3,1959 St. Stephens Broadway, Balto., Maryland.

Abingdon, Maryland.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

673 CERTIFICATE OF DEATH

PC667

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: D.O.A.,
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood, Rural
d. STREET ADDRESS: Norris's Corner
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: H. — Last: Bearsch

4. DATE OF DEATH: Month: Jan. — Day: 6, — Year: 19 59

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 20, 1907

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Gen., Mdse.,

11. BIRTHPLACE (State or foreign country): Edgewood, Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.,

13. FATHER'S NAME: Geroge Bearsch

14. MOTHER'S MAIDEN NAME: Annie Gunther

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 218-32-0822

17. INFORMANT — Address: Morrell H. Bearsch, Edgewood, R.D., Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. ft. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-4, 19 59 to 1-6, 19 59 that I last saw the deceased alive on 1-5, 19 59, and that death occurred at 8 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Gerald C Palmer M.D. — ADDRESS (Street, city or town, state): Bel Air, Maryland — DATE SIGNED

PHYSICIAN'S NAME (Type): Gerald C. Palmer — Bel Air, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan. 9, 1959

22c. NAME OF CEMETERY OR CREMATORY: Trinity Lutheran

22d. LOCATION (City, town, or county): Joppa, Harford, (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K McComas Jr — ADDRESS: Abingdon, Maryland

24a. REC'D BY REGISTRAR — DATE: JAN 12 '59

24b. REGISTRAR'S SIGNATURE: [illegible] S. Evans

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completed as filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ADC 1-55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

698 CERTIFICATE OF DEATH

P6668

Reg. Dist. No. .....

1. PLACE OF DEATH

County: Harford — Maryland

City or Town (If outside corporate limits, write RURAL and give nearest town): RURAL, Bel Air

Length of stay (in this place): 5 months

Hospital or Institution or Street Address: RFD #2, Bel Air

2. USUAL RESIDENCE (HOME) OF DECEASED

State: Maryland — County: Harford

City or Town (If outside corporate limits, write RURAL and give nearest town): X RURAL - Bel Air

Street Address (If rural give location): 1 c/o Ernest B. Kirkpatrick, RFD #2, Bel Air

3. NAME OF DECEASED (Type or Print): (First) (Christianna) CHRISTIANA (Middle) CATHERINE (Last) BEVANS

4. DATE OF DEATH (Month) January (Day) 3, (Year) 19 59

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F	W	Widow	November 18, 1876	82 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	--	Maryland	U. S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Harman Schlissler	Catherine Kate

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no	--	Son-in-law: E. B. Kirkpatrick, RD #2, Bel Air, Md.

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 4 / IMMEDIATE CAUSE (A)	Congestive heart failure	1 hour
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)	Arteriosclerotic cardiovascular disease	several years
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	1) recent cerebral thrombosis 2) fracture of right hip	2 or 3 weeks 6 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20 AUTOPSY?
--	--	YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 24, 1958, to Jan. 3, 1959, that I last saw the deceased alive on Dec. 30, 1958, and that death occurred at 12:50 A M, from the causes and on the date stated above.

SIGNATURE: Paul S. Stonesifer Jr. — Paul S. Stonesifer, Jr., M.D. — ADDRESS (Street, city, town, state): 115 Fulford Ave., Bel Air, Md. — DATE SIGNED: Jan. 3, '59

23. (BURIAL) CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	1-6-59	Meadow Ridge	Bald Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
JAN 6 '59		Leonard J Kuck	5305 Harford

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00669

699

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY: Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Forest Hill

LENGTH OF STAY (in this place): lifetime

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Box 215, RFD, Forest Hill

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL -- Forest Hill

STREET ADDRESS (If rural give location): Box 215, RFD, Forest Hill

3. NAME OF DECEASED (Type or Print): (First) JAMES (Middle) HENRY (Last) BLAKE

4. DATE OF DEATH (Month) January (Day) 31 (Year) 19 59

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	October 29, 1877	81 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farming	Maryland	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Blake	Martha O'Donnell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no	--	219-36-0214	Alvin Blake (son) Box 215, RFD, Forest Hill, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A)	Myocardial Infarction	6 hrs.
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)	Coronary thrombosis	6 hrs.
DUE TO (C)	Arteriosclerotic cardiovascular disease	4 - 5 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Residual of cerebrovascular accident	18 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 31, 19 59, to ---, 19, that I last saw the deceased alive on, 19, and that death occurred at 12:05 M, from the causes and on the date stated above.

SIGNATURE Paul S. Stonesifer, Jr. Deputy Medical Examiner M.D. **ADDRESS** (Street, city, town, state) 115 Hartford Ave., Bel Air, Md. **DATE SIGNED** 1/31/59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 3, 1959	St. Ignatious Cemetary	Hickory (Harford) Md.

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
DATE FEB 3 '59		Joseph W. Foster W. Broadway & Williams St. Bel Air, Maryland

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third (copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

700 CERTIFICATE OF DEATH

PCG7a

Reg. Dist. No. .....

1. PLACE OF DEATH

COUNTY Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston

LENGTH OF STAY (in this place) 15 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Fallston RD

STREET ADDRESS (If rural give location) / Plumtrille Road

3. NAME OF DECEASED (Type or Print) (First) Cora (Middle) Leona (Last) Blevins

4. DATE OF DEATH (Month) Jan. (Day) 7 (Year) 1959

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Oct. 15, 1871	87 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Lansing N.J.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robert Francis	— Stewart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		-------	Miss. Francis Blevins Fallston Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE	(A)	Congestive Heart Failure	3 weeks
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B)	Extreme Thoraco-Lumbar Kyphosis	Prob.10 yrs.
	DUE TO (C)	Osteo Arthritis	32 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 3, 1959, to Jan. 7, 1959, that I last saw the deceased alive on Jan. 6, 1959, and that death occurred at 5 a.M, from the causes and on the date stated above.

SIGNATURE Robt Barthel M.D. **ADDRESS** (Street, city, town, state) Forest Hill, Maryland **DATE SIGNED** Jan.7,1959

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/9/1959	Oak Grove	Fountain Green Md.

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE JAN 12			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

701 CERTIFICATE OF DEATH

00671
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural
c. LENGTH OF STAY IN 1b Lifelong
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bel Air
e. STREET ADDRESS

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Dennis Middle Lee Last Bradley
4. DATE OF DEATH Month June Day 8 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Dec 17 1874
9. AGE (In years last birthday) 84 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical
10b. KIND OF BUSINESS OR INDUSTRY Water Company
11. BIRTHPLACE (State or foreign country) Faulston, Md
12 CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Daniel Bradley
14. MOTHER'S MAIDEN NAME Maria Tahaney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16 SOCIAL SECURITY NO. 215-03-3259
17. INFORMANT Address Mrs Alice V. Bradley - Bel Air Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO - RESP. FAILURE — INTERVAL BETWEEN ONSET AND DEATH 2 Days
11 00.0
DUE TO (b) ADVANCED ARTERIOSCLEROSIS + CONGESTIVE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) HEART FAILURE — 2 YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 52, to 8 June, 19 59, that I last saw the deceased alive on June 7, 19 59, and that death occurred at 2:17 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE H.R. Sidwell M.D. ADDRESS (Street, city or town, state) 401 S. Main St. Bel Air, Md DATE SIGNED June 9
PHYSICIAN'S NAME (Type) H.R. SIDWELL M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF Jan 12, 1959
22c. NAME OF CEMETERY OR CREMATORY St Johns Catholic
22d LOCATION (City, town, or county) (State) Long Green Md

23 FUNERAL DIRECTOR'S SIGNATURE W.H. Archer ADDRESS Benson, Md.
24a. REC'D BY REGISTRAR DATE JAN 12 59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

674

00672 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 5 HRS
d. NAME OF HOSPITAL (If not in Hospital, give street address) OR INSTITUTION: HARFORD Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 BEL AIR
d. STREET ADDRESS: 13 N. REID
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MAMIE Middle BOLLES Last CARSWELL

4. DATE OF DEATH: Month JANUARY Day 24 Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 1877

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: ____

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HIRAM BOLLES

14. MOTHER'S MAIDEN NAME: Emily VAN METER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: No

17. INFORMANT: Mrs. Mary C. Mannion
Address: 13 N. Reid St., Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: few hrs.

DUE TO (b): Arteriosclerotic Cardiovascular Disease

DUE TO (c): Chronic Hypertensive Cardiovascular Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ____

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): ____

20c. TIME OF INJURY: Month ____ Day ____ Year ____ Hour ____ a. m. / p. m. 19____

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ____

20f. (City or town) ____ (County) ____ (State) ____

21. I certify that I attended the deceased from 1/23/59, 19__ to 1/24/59, 19__ that I last saw the deceased alive on 1/24/59, 19__ and that death occurred at 12:30 A.M. from the causes and an the date stated above.

ACTUAL SIGNATURE: Edward C. Loc, M.D. — M.D. — ADDRESS (Street, city or town, state): 211 N. Union Ave., Havre de Grace, Md. — DATE SIGNED: 1/24/59

PHYSICIAN'S NAME (Type): Edward C. Loc, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): ____

22b. DATE THEREOF: Jan. 26, 1959

22c. NAME OF CEMETERY OR CREMATORY: Springfield

22d. LOCATION (City, town, or county) / (State): Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. S. Bailey — ADDRESS: Darlington, Md.

24a. REC'D BY REGISTRAR — DATE: JAN 27 1959

24b. REGISTRAR'S SIGNATURE: ____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00673 32

Reg. Dist. No. 702

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Walter Middle Chamberlain Last
4. DATE OF DEATH Month Jan Day 27 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH June 1, 1883
9. AGE (In years last birthday) 75 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Harford Co Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Walter Chamberlain
14. MOTHER'S MAIDEN NAME Laura Forwood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO 218-32-2
17. INFORMANT Mrs. Laura Chamberlain Address 486 Street, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH 24yrs
4341
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o. m p. m 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1958, to Jan 27, 1959, that I last saw the deceased alive on Jan 26, 1959, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE Dudley Phillips MD — ADDRESS (Street, city or town, state) Darlington Md — DATE SIGNED 1/29/59
PHYSICIAN'S NAME (Type) Dudley Phillips — Darlington, Md — 1/29/59

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF Jan 31, 1959
22c. NAME OF CEMETERY OR CREMATORY Huber Cem
22d. LOCATION (City, town, or county) Harford Co (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE H. S. Bailey — ADDRESS Darlington Md
24a. REC'D BY REGISTRAR DATE JAN 5 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

675 **CERTIFICATE OF DEATH** Reg. Dist. No. 06674

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood
c LENGTH OF STAY IN 1b 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Upper Chesapeake Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood
d. STREET ADDRESS XXXXXXXXX R.D. #3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First NEIL XXXXX Middle Franklin Last Collier
4. DATE OF DEATH Month January Day 7 Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH 16 June 1895
9. AGE (In years last birthday) 63 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner
10b. KIND OF BUSINESS OR INDUSTRY Coal Mines
11. BIRTHPLACE (State or foreign country) Virginia
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME ? Creed F. Collier
14. MOTHER'S MAIDEN NAME ? Willie Ann Edens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown, If yes, give war or dates of service) No
16. SOCIAL SECURITY NO 233 09 9317
17 INFORMANT Richard Collier son Address 138 E Main St Aberdeen

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis (primary
DUE TO rectum - Status remote resection) 18 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from October, 19__, to 1-9-, 1959, that I last saw the deceased alive on 1-8-59, and that death occurred at 8:25 a.m. from the causes and on the date stated above.

ACTUAL SIGNATURE Peter P. Rodman MD
ADDRESS (Street, city or town, state) 8 Law Street
DATE SIGNED 1-10-59
PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D. Aberdeen, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1/11/59
22c NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens,
22d LOCATION (City, town or county) Bel Air, (State) Maryland

23. FUNERAL DIRECTOR'S SIGNATURE John A. Tarring
ADDRESS Aberdeen, Md.
24a. REC'D BY REGISTRAR DATE JAN 12 '59
24b REGISTRAR'S SIGNATURE

Tarring Funeral Home

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be affixed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

203

CERTIFICATE OF DEATH

00675

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: US Army Hospital, Aberdeen Prov.Gd.,Md.

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: West Virginia — b. COUNTY: Cabell
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Milton, West Virginia
d. STREET ADDRESS: Church Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Rose — Middle Baxter — Last Cunningham

4. DATE OF DEATH: Month January — Day 14 — Year 1959

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 14 December 1877

9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Felix Josephus Baxter

14. MOTHER'S MAIDEN NAME: Sarah Prudence Duffy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: ———

17. INFORMANT — Address: LtCol Harvey M. Hardin, Aberdeen Proving Gd.,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
170 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Metastatic carcinoma — Unknown
DUE TO
(c): Carcinoma of breast — 1.5 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Megaloblastic anemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): No injury or accident

20c. TIME OF INJURY Hour ___ a. m. p. m. Month ___ Day ___ Year 19 ___

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 January, 1959, to Death, 14 Jan 59, that I last saw the deceased alive on 5:30 PM, 14 Jan 1959, and that death occurred at 10:10 PM, from the causes and on the date stated above

ACTUAL SIGNATURE: D Hamaty Capt MC M.D — ADDRESS (Street, city or town, state): Aberdeen Proving Ground, Maryland — DATE SIGNED: 14 Jan 59

PHYSICIAN'S NAME (Type): DANIEL HAMATY, Capt, MC

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal — 22b. DATE THEREOF: 1/15/1959 — 22c. NAME OF CEMETERY OR CREMATORY: Sutton Cemetery — 22d. LOCATION (City, town, or county) (State): Sutton, West Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: John T. Garrity — ADDRESS: aberdeen. maryland

24a. REC'D BY REGISTRAR DATE: JAN 3 59 — 24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OFFICIAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

676

CERTIFICATE OF DEATH

DC676 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY HARFORD MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE
c. LENGTH OF STAY IN 1b 1 HR. 50 M.n.
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION HARFORD Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEL AIR
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First HERBERT Middle J Last DAVIS

4. DATE OF DEATH Month JANUARY Day 28 Year 1954

5. SEX MALE
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Aug. 4, 1901
9. AGE (In years last birthday) 57 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER
10b. KIND OF BUSINESS OR INDUSTRY State Road
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Riley DAVIS
14. MOTHER'S MAIDEN NAME Dilly Coble

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO 212-09-7743
17. INFORMANT Address Mrs. Anna Davis Bel Air, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anterolateral Myocardial Infarction 1 day
DUE TO
(b) Coronary thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c) Arteriosclerotic Cardiovascular Disease 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 28th, 19 54 to Jan. 28th 19 54 that I last saw the deceased alive on 11:30 p.m. 1/28 19 54 and that death occurred at 11:55 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Edward C. Lee M.D.
ADDRESS (Street, city or town, state) 211 N. Main Ave. Bel Air, Md.
DATE SIGNED 1/28/54 11:45 p.m.
PHYSICIAN'S NAME (Type) Edward C. Lee, M.D., Bel Air, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF Feb. 1, 1954
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion
22d LOCATION (City, town, or county) (State) Bel Air, Harford, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McComas
ADDRESS Abingdon, Maryland.
24a. REC'D BY REGISTRAR DATE FEB 2 '54
24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

704 **CERTIFICATE OF DEATH**

0667

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): High Point
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X High Point
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print): First Frank — Middle Oliver — Last Foard

4. DATE OF DEATH: Month January — Day 11 — Year 19 59

5 SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 18, 1880
9. AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: General Farming
11 BIRTHPLACE (State or foreign country): Pleasantville Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Oliver S. Foard
14. MOTHER'S MAIDEN NAME: Mary Harkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: 215-36-8099
17. INFORMANT: F. Russell Foard — Address: Forest Hill Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar Pneumonia, terminating — INTERVAL BETWEEN ONSET AND DEATH: 4days
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Cerebral hemorrhage — 37 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 7, 19 58, to Jan. 11, 19 59, that I last saw the deceased alive on Jan. 10, 19 59, and that death occurred at 4:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P Hudson M.D. — ADDRESS (Street, city or town, state): Forest Hill, Md. — DATE SIGNED: 1/12/59

PHYSICIAN'S NAME (Type): Willard P. Hudson, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/13/1959
22c. NAME OF CEMETERY OR CREMATORY: Centre
22d. LOCATION (City, town, or county) (State): Forest Hill Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: [illegible]

24a. REC'D BY REGISTRAR DATE: JAN 15 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

90678

705 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullman Rd
c. LENGTH OF STAY IN 1b 54 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullman Road
d. STREET ADDRESS Forest Hill R.D
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: MARY Middle: ANNE Last: GRAY

4. DATE OF DEATH Month: JAN Day: 31 Year: 1959

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Dec 22, 1919

9. AGE (In years last birthday) 39 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10b. KIND OF BUSINESS OR INDUSTRY at Home

11. BIRTHPLACE (State or foreign country) Richmond Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Wheatland T Tucker

14. MOTHER'S MAIDEN NAME Marie L Rudd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT Address Frances A Gray Forest Hill Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY occlusion of Coronary ostia — INTERVAL BETWEEN ONSET AND DEATH: Minutes

416X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Coronary insufficiency due to scarring — 13 yrs

DUE TO

(c) Rheumatic carditis — 30 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 19 55, to 31 Jan, 19 59, that I last saw the deceased alive on 31 Jan, 19 59, and that death occurred at 7:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Thos. A.E. Moseley Jr. M.D. ADDRESS (Street, city or town, state) Forest Hill Md DATE SIGNED

PHYSICIAN'S NAME (Type) Thos. A.E. Moseley, Jr. Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Feb 3 59

22c. NAME OF CEMETERY OR CREMATORY Mount Rest

22d. LOCATION (City, town, or county) (State) La Plata Md.

23. FUNERAL DIRECTOR'S SIGNATURE Robert M Glass Jr Robert Bodmer ADDRESS

24a. REC'D BY REGISTRAR FEB 4 '59

24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item B [illegible] G 2 [illegible] 7 9 88

00679

706 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Fallston
c. LENGTH OF STAY IN 1b: 9 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ---

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fallston
d. STREET ADDRESS: Rural Friendship Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Florence Middle White Last Guild
4. DATE OF DEATH: Month Jan Day 16 Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec 29 1888
9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Arkansas City - Kansas
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: Oliver Hill White
14. MOTHER'S MAIDEN NAME: Carolyn Hill Kansas
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Stacy R. Guild Address: Fallston Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vascular Accident
DUE TO (b): arterio-sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): ---
INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. 1.30 Month Jan Day 16 Year 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Fallston (County) Harford (State) Md

21. I certify that I attended the deceased from April 1953 to Jan 1959, that I last saw the deceased alive on Jan 14 1959, and that death occurred at 1.30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lay Martin M.D. ADDRESS (Street, city or town, state): 1201 Calvert St Baltimore Md DATE SIGNED: Jan 16/59
PHYSICIAN'S NAME (Type): Lay Martin

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: Jan 19. 1959
22c. NAME OF CEMETERY OR CREMATORY: Greenmount
22d. LOCATION (City, town, or county): Balto (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: W T Archer ADDRESS: Benson Md
24a. REC'D BY REGISTRAR DATE: JAN 23 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

707 CERTIFICATE OF DEATH

Reg. Dist. No. 0068

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas; Middle:; Last: Gunther

4. DATE OF DEATH: Month: Jan.; Day: 22; Year: 19 59

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar. 17, 1871

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Owner

11. BIRTHPLACE (State or foreign country): Harford Co., Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Miss Bessie Gunther — Address: Aberdeen, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Generalized Arteriosclerosis — 2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Chronic Prostatitis
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January, 19 59, to Jan. 22, 19 59, that I last saw the deceased alive on Jan 22, 19 59, and that death occurred at 0 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Andre Weiss M.D. — ADDRESS (Street, city or town, state): 114 W. Bel Air Av. Aberdeen, Md. — DATE SIGNED:

PHYSICIAN'S NAME (Type): ANDRE WEISS MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan. 25, 1959

22c. NAME OF CEMETERY OR CREMATORY: Cokesbury Memorial

22d. LOCATION (City, town, or county) (State): Abingdon, Harford, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: Frank K. Mowell — ADDRESS: Abingdon, Maryland

24a. REC'D BY REGISTRAR DATE: JAN 27 '59

24b. REGISTRAR'S SIGNATURE: C. L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

708 CERTIFICATE OF DEATH

00681
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): RD 1

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: RD 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles Middle William Last Hall
4. DATE OF DEATH: Month January Day 2 Year 1959
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Sept. 12, 1888
9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months 3 Days 21 IF UNDER 24 HRS: Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10b. KIND OF BUSINESS OR INDUSTRY: Board of Education
11. BIRTHPLACE (State or foreign country): Harford County Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Will Hall
14. MOTHER'S MAIDEN NAME: Eliza Hopkins Smith
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO.: 222-05-0467
17. INFORMANT: Mrs Mabel Hart Address 612 South Union Ave Havre de Grace, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Arteriosclerotic C V disease — INTERVAL BETWEEN ONSET AND DEATH —
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-29-1958 to 1-2 1959 that I last saw the deceased alive on 1-1 1959, and that death occurred at 8 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gerald Palmer M.D.
ADDRESS (Street, city or town, state): Bel Air Md
DATE SIGNED: 1-2-59
PHYSICIAN'S NAME (Type): Gerald Palmer MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan 5, 1959
22c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery
22d. LOCATION (City, town, or county) (State): Churchville Md
23. FUNERAL DIRECTOR'S SIGNATURE: Elmer E Bullock ADDRESS: Havre de Grace, Md
24a. REC'D BY REGISTRAR DATE JAN 2 59
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00682

709 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryman
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryman
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HENRY — Middle — Last HARRIS

4. DATE OF DEATH: Month January — Day 13 — Year 1959

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 15 October 1881

9. AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Dishwashing

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: (Unknown)

14. MOTHER'S MAIDEN NAME: Elizabeth Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 218-07-7310

17. INFORMANT — Address: Mary Hollingsworth, Perryman, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Hypertensive Arteriosclerotic Heart disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 22, 19 58, to Jan. 12, 1959, that I last saw the deceased alive on January 12, 1959, and that death occurred at 12:20 am from the causes and on the date stated above.

ACTUAL SIGNATURE: George T. Stansbury, M.D.
ADDRESS (Street, city or town, state): 569 Revolution St.
DATE SIGNED: 1-14-59

PHYSICIAN'S NAME (Type): George T. Stansbury, M.D. Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-16-59

22c. NAME OF CEMETERY OR CREMATORY: Ashury Cemetery

22d. LOCATION (City, town, or county) (State): Loreley, Balto. Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Loring
ADDRESS: Loring Funeral Home Aberdeen, Md.

24a. RECD BY REGISTRAR DATE: JAN 19 '59

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00683

Reg. Dist. No. 627

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 1 hour

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 1 Havre de Grace

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital
d. STREET ADDRESS: 1 Lewis Lane
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Minnie Middle LOLLA Last Harrison
4. DATE OF DEATH: Month January Day 17 Year 1959
5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JULY 29, 1874
9. AGE (In years last b'thday): 84 yrs
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): NEB.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: BRIGGS UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: —
17. INFORMANT: Address: Mrs MINNIE SIMPERS, ELKTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Asphixia due to Tracheal Obstruction
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
9210
INTERVAL BETWEEN ONSET AND DEATH: —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Choked on piece of liver
20c. TIME OF INJURY: Hour 6 a.m. p.m. Month, Day, Year 1-17 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Havre de Grace (County) Harford (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer
M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
Bel Air Md DATE SIGNED 1-18-59
EXAMINER'S NAME (Type): Gerald C Palmer M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: JAN. 20, 1959
22c. NAME OF CEMETERY OR CREMATORY: ELKTON CEM.
22d. LOCATION (City, town, or county): ELKTON, (State) MD

23. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell
ADDRESS: HAVRE DE GRACE, MD
24a. REC'D BY REGISTRAR: DATE JAN 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Harris

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director or [illegible] 4 should be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

678

CERTIFICATE OF DEATH

00684

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE

c. LENGTH OF STAY IN 1b: 34 DAYS

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PERRYVILLE

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

d. STREET ADDRESS: BOX # 36

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: NETTIE — Middle: EVELYN — Last: HOLLY

4. DATE OF DEATH: Month: JANUARY — Day: 23 — Year: 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/8/1898

9. AGE (In years last birthday): 60 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10b. KIND OF BUSINESS OR INDUSTRY: Cogswell Construction

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE J Holly

14. MOTHER'S MAIDEN NAME: FLORENCE HAMMOND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT — Address: Mrs. Charles M Reynolds — Offord, Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Ca. in Liver and Mesenteric — INTERVAL BETWEEN ONSET AND DEATH: 8 months
DUE TO: Symptomatic
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Adenocarcinoma of Sigmoid Colon — 3 yrs (Had Dx 1 yr)
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 26th, 1958 to 1/23, 1959 that I last saw the deceased alive on 1/23rd, 1959, and that death occurred at 6:35 A M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D

ADDRESS (Street, city or town, state): 211 N. Union Ave.

DATE SIGNED: 1/25/59

PHYSICIAN'S NAME (Type): Edw. J. [illegible], Jr. M.D

Harford Memorial Hospital 10 A.M.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 1/26/59

22c. NAME OF CEMETERY OR CREMATORY: Hopewell

22d. LOCATION (City, town, or county) (State): New Port Richard Md

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son

ADDRESS: Havre de Grace, Md

24a. REC'D BY REGISTRAR DATE: JAN 27 '59

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

710 CERTIFICATE OF DEATH

00685
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural—Bel Air,
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Convalescent Home

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: New York City
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARIE — Middle — Last HOZA

4. DATE OF DEATH: Month Jan. — Day 21 — Year 1959

5. SEX: Fem.

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 11, 1887

9. AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dress Maker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Czechoslovakia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Hoza

14. MOTHER'S MAIDEN NAME: Stetkarova

15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 082-22-5796

17. INFORMANT: Frank Benisek — Address: Belcamp, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia-hypostatic — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Chr. hypertensive cardio-vascular disease — ??

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X

DUE TO (c): Cerebral hemorrhage with left hemiparesis. (9/20-58)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 29, 1957, to Jan. 1, 1959, that I last saw the deceased alive on Jan. 1, 1959, 19, and that death occurred at 11:20 p.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D. — ADDRESS (Street, city or town, state): Forest Hill, Md. — DATE SIGNED: 1-2-59

PHYSICIAN'S NAME (Type): Willard P. Hudson, M.D. — Forest Hill, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: Jan-5-1959

22c. NAME OF CEMETERY OR CREMATORY: Greenmount

22d. LOCATION (City, town, or county) (State): Baltimore - Md

23. FUNERAL DIRECTOR'S SIGNATURE: Earl R Wolverton — ADDRESS: Funeral Home Inc 6306 - Belair Rd - Baltimore - 6, Md

24a. REC'D BY REGISTRAR DATE:

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

679

CERTIFICATE OF DEATH

00686

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 18 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital
e. STREET ADDRESS:
f. IS RESIDENCE ON A FARM? YES ☐ NO ☐

2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darlington

3. NAME OF DECEASED (Type or print): First: Clement — Middle: Morton — Last: Hutchinson
4. DATE OF DEATH: Month: January — Day: 19 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 11, 1898
9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALES EXECUTIVE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.Y. New York
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: MORTON CLEMENT HUTCHINSON, Sr.
14. MOTHER'S MAIDEN NAME: Kathrine E. Moseley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service) WWI-1929
16. SOCIAL SECURITY NO. 103-12-7823
17. INFORMANT: Mrs. Mat. Hutchinson — Address: Darlington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Chronic lymphocytic leukemia — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1948, to Jan 19, 1959, that I last saw the deceased alive on Jan 19, 1959, and that death occurred at 11:55 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Dudley Phillips, M.D. — ADDRESS (Street, city or town, state): Darlington Md — DATE SIGNED: 1/19/59
PHYSICIAN'S NAME (Type): Dudley Phillips — DARLINGTON, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Jan. 20, 1959 — 22c. NAME OF CEMETERY OR CREMATORY: Greenmount Cem — 22d. LOCATION (City, town or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: H. E. Bailey Darlington Md
REC'D BY REGISTRAR DATE: JAN 26 '59
24b. REGISTRAR'S SIGNATURE: C. Mary S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

711 **CERTIFICATE OF DEATH**

00687 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel - Air
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): R.D. Bel-air

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X. Bel Air
d. STREET ADDRESS: Rock Spring Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARENCE Middle A. Lost JACKSON

4. DATE OF DEATH: Month 1 Day 8 Year 1959

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 25, 1900
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months 4 Days 13
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm worker
10b. KIND OF BUSINESS OR INDUSTRY: Cattle Farms
11. BIRTHPLACE (State or foreign country): Churchville, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: George Jackson
14. MOTHER'S MAIDEN NAME: Eliza Wiggins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War I
16. SOCIAL SECURITY NO.: 218-30-6207
17. INFORMANT: Mrs Stella E. Jackson
Address: Rock Spring Rd Bel-Air, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coron. Insuf. Senile — INTERVAL BETWEEN ONSET AND DEATH: Hours

DUE TO (b): Arteriosclerosis — 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Apoplexy Cerebral Hemorrhage Hypertension Syn — 6 days

445X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Enlargement of prostate 8 yrs

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 22, 1958 to Jan 8, 1959, that I last saw the deceased alive on Jan 5, 1959, and that death occurred at 6:15 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: H P Sidwell, M.D. ADDRESS (Street, city or town, state): [illegible] DATE SIGNED: 1-12-59

PHYSICIAN'S NAME (Type): H P SIDWELL

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/12/59
22c. NAME OF CEMETERY OR CREMATORY: Tabernacle Cemetery
22d. LOCATION (City, town, or county) (State): Benson, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Elmer E. Bullock
ADDRESS: Havre de Grace, Md.
24a. REC'D BY REGISTRAR DATE: JAN 13 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00688

680 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 1 HR.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: PA. b. COUNTY: YORK
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DELTA
d. STREET ADDRESS: MAIN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First SUSAN Middle ANN Last Kilgore
4. DATE OF DEATH: Month JAN. Day 21 Year 1959

5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 25, 1958
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months 7 Days 27
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Oscar S. Kilgore
14. MOTHER'S MAIDEN NAME: Audrey Wiley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Address: OSCAR KILGORE, DELTA, PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Exhaustion — INTERVAL BETWEEN ONSET AND DEATH: 10 days
571.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 25, 1958 to Jan. 21, 1959 that I last saw the deceased alive on Jan. 21, 1959, and that death occurred at 7:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robt Barthel M.D.
ADDRESS (Street, city or town, state): FOREST HILL, MD.
DATE SIGNED: Jan 21 1959
PHYSICIAN'S NAME (Type): ROBERT BARTHEL

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1-23-59
22c. NAME OF CEMETERY OR CREMATORY: PINE GROVE
22d. LOCATION (City, town, or county) (State): SUNNYBURN, YORK CO., PA.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Hakins
ADDRESS: DELTA, PA.
24a. REC'D BY REGISTRAR DATE: JAN 26 '59
24b. REGISTRAR'S SIGNATURE: Chas. L. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

681 CERTIFICATE OF DEATH

Reg. Dist. No. 00689

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. — b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colora
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First: William Middle: Thomas Last: Kyle

4. DATE OF DEATH Month: Jan. Day: 13, Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: Aug. 29, 1877
9. AGE (In years last birthday) 81 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Hand
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Calum Edward Kyle
14 MOTHER'S MAIDEN NAME: Jennie Lynch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: John Kyle — Address: Son Colora, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERITONITIS — INTERVAL BETWEEN ONSET AND DEATH

CLX.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) RUPTURE OF BLADDER - PELVIC ABSCESS
DUE TO (c) NODULAR PROSTATIC HYPERPLASIA

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-11, 1959, to 1-13, 1959, that I last saw the deceased alive on 1-13, 1959, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D. Wm. K. Brendle — ADDRESS (Street, city or town, state) Havre de Grace, Md. — DATE SIGNED 1-14-59

PHYSICIAN'S NAME (Type) Wm. K. BRENDLE

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF 1-17-1959
22c NAME OF CEMETERY OR CREMATORY Harmony Chapel Cem.
22d LOCATION (City, town, or county) (State) Conowingo, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Vernon E. McMullen — ADDRESS Rising Sun, Md.
24a. REC'D BY REGISTRAR DATE JAN 19 '59
24b REGISTRAR'S SIGNATURE Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

682 CERTIFICATE OF DEATH

Reg. Dist. No. 00690

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 5 Mths
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 18 Royal Terrace

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 18 Royal Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dora — Middle: H. — Last: Lagle
4. DATE OF DEATH: Month: Jan. — Day: 19 — Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug 21 1893
9. AGE (If years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Lafe Highfill
14. MOTHER'S MAIDEN NAME: Molly Furkhouser
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: #33-18-7634
17. INFORMANT: Harry K. Hardin — Address: Taylor Ky

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive Arteriosclerotic Heart Disease
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: 7 Hrs. / Yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11:45 am 1/19, 19 59, to 6:45 pm 1/19, 19 59, that I last saw the deceased alive on Jan 19, 19 59, and that death occurred at 6:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William H. Kirk Jr. M.D. — ADDRESS (Street, city or town, state): 617 W. Bel Air Ave. — DATE SIGNED: Jan 20, 1959

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/20/59
22c. NAME OF CEMETERY OR CREMATORY: Louisville Memorial
22d. LOCATION (City, town, or county) (State): Louisville Kentucky

23. FUNERAL DIRECTOR'S SIGNATURE: John G Torring — ADDRESS: Aberdeen Maryland

24a. REC'D BY REGISTRAR DATE: JAN 23 '59
24b. REGISTRAR'S SIGNATURE: C[illegible] S. Haus

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

683

CERTIFICATE OF DEATH

00691

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 24 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: R D II
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elizabeth Middle Sarah Last Little

4. DATE OF DEATH: January 30 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 19 1888

9. AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm Curry

14. MOTHER'S MAIDEN NAME: Sarah Jane Cantler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT (Address): Mrs. Natalie F. Pyle Havre de Grace R.D. #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
(b): Cerebral Thrombosis — 2 Days
DUE TO
(c): Cerebral Arteriosclerosis — 2 Yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1/25/59 to 1/30/59 that I last saw the deceased alive on January 30, 1959, and that death occurred at 10:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. H. MacDonnell, M.D.
ADDRESS (Street, city or town, state): 401 S. Union Ave, Havre de Grace, Md.
DATE SIGNED: 1/31/59
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Feb. 2, 1959
22c. NAME OF CEMETERY OR CREMATORY: Angel Hill Cem
22d. LOCATION (City, town, or county) (State): Havre de Grace, MD

23. FUNERAL DIRECTOR'S SIGNATURE: R Madison McDaniel
ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR
DATE: FEB 3 '59

24b. REGISTRAR'S SIGNATURE

D 1 X

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

712

00692

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Joppa
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: J.H. — Last: Lyons

4. DATE OF DEATH: Month: January — Day: 28, — Year: 1959

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 21, 1931

9. AGE (In years last birthday): 27 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Metal Worker

10b. KIND OF BUSINESS OR INDUSTRY: Automobile

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.,

13. FATHER'S NAME: Jess A. Lyons

14. MOTHER'S MAIDEN NAME: Elizabeth Porter

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): 1952

16. SOCIAL SECURITY NO: 216-28-9181

17. INFORMANT: Mrs. Elizabeth Anderson, Address: Joppa, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Artery Sclerosis with Coronary Thrombosis of Left Anterior Descending Artery

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. p. m. Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from. Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Russell S Fisher M D

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: January 29, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan. 31, 1959

22c. NAME OF CEMETERY OR CREMATORY: Trinity Lutheran
ADDRESS: Abingdon, Maryland.

22d. LOCATION (City, town, or county) (State): Joppa, Harford, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard L. McComas

24a. REC'D BY REGISTRAR DATE: FEB 2 59

24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the [redacted] care, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be recorded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in our files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

X

Nov.21,1931

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

684 **CERTIFICATE OF DEATH**

00693
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 1 day.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x White Ford.
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First ALLEN Middle IRVIN Last MANAHAN

4. DATE OF DEATH: Month January Day 14 Year 1959.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 6, 1958

9. AGE (In years last birthday) yrs: IF UNDER 1 YEAR Months 7 Days 8; IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): HAVRE DE GRACE, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ELLSWORTH MANAHAN

14. MOTHER'S MAIDEN NAME: MARY JANE LEONARD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Address: ELLSWORTH MANAHAN, WHITEFORD, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL EDEMA — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): HYPERPYREXIA — 1 day
DUE TO
(c): OVERWHELMING VIRAL INFECTION (? PNEUMONITIS)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JAN. 14, 1959 to JAN. 14, 1959 that I last saw the deceased alive on JAN. 14, 1959, and that death occurred at 11:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Belinda L. Marbella, M.D. ADDRESS (Street, city or town, state): Harford Mem. Hosp. DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 1-17-59

22c. NAME OF CEMETERY OR CREMATORY: SLATE RIDGE

22d. LOCATION (City, town, or county) (State): DELTA, PENNA.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John H. Harkins Delta, Pa.

24a. REC'D BY REGISTRAR DATE: JAN 13 59

24b. REGISTRAR'S SIGNATURE: [illegible] L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

685

CERTIFICATE OF DEATH

00696

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 3 Chesapeake Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Frank — Middle: — — Last: Maya Jr.

4. DATE OF DEATH: Month: 11 — Day: 17 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/30/1900

9. AGE (In years last birthday): 58 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Quary

11. BIRTHPLACE (State or foreign country): Hayti Tennessee

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Frank Maya Sr

14. MOTHER'S MAIDEN NAME: Hanna Mudsont

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mrs. Della Maya — Address: 3 Chesapeake Drive Havre de Grace Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	PULMONARY EDEMA	1 HR
DUE TO	162.1	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (b)	CORONARY INSUFFICIENCY	1 WEEK
DUE TO (c)	BRONCHOGENIC CARCINOMA	6 WEEKS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from DEC 8, 1956, to JAN 17, 1957, that I last saw the deceased alive on JAN 17, 1957, and that death occurred at 7:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. R. Ross M.D. — ADDRESS (Street, city or town, state): 200 N. Union Ave. — DATE SIGNED: 1/21/57

PHYSICIAN'S NAME (Type): L.R Ross — Havre de Grace, Md

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 1/20/57

22c. NAME OF CEMETERY OR CREMATORY: Angel Hill

22d. LOCATION (City, town, or county) (State): Havre de Grace Md

23. FUNERAL DIRECTOR'S SIGNATURE: Fanning Funeral Dir. — ADDRESS: Havre de Grace Md.

24a. REC'D BY REGISTRAR DATE: JAN 23 [illegible]

24b. REGISTRAR'S SIGNATURE

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

686 — 60695 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 9yr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DoA Office Dr. G E Palmer

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: RD 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle Lee — Last Morrison
4. DATE OF DEATH: Month January — Day 18 — Year 19 59

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 21, 1958
9. AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months 2 Days 27 — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Harford Co., Md.,
12. CITIZEN OF WHAT COUNTRY?: U.S.,

13. FATHER'S NAME: Avis W. Morrison
14. MOTHER'S MAIDEN NAME: Jessie G. Dowell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Avis W. Morrison, Aberdeen R.D., Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH
491X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ① Prematurity (8 mo) ② Autonomosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald E Palmer M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Gerald E Palmer M.D.
Bel Air, Md. DATE SIGNED 1-18-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 20, 1959
22c. NAME OF CEMETERY OR CREMATORY: Free Will Baptist
22d. LOCATION (City, town, or county) (State): Bel Air, Harford, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard A McComas Jr
ADDRESS: Abingdon, Maryland.
24a. REC'D BY REGISTRAR DATE: JAN 22 59
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, omitting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

XV4

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

687

Reg. Dist. No. 00696

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Delaware
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark
d. STREET ADDRESS: 821 Elkton Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Newell — Middle: — Last: Floyd

4. DATE OF DEATH: Month: January — Day: 6 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-16-1917

9. AGE (In years last birthday): 41 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Mgr

10b. KIND OF BUSINESS OR INDUSTRY: Education

11. BIRTHPLACE (State or foreign country): Vermont

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Guy Newell

14. MOTHER'S MAIDEN NAME: Marion Goneo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 008-12-1025

17. INFORMANT: Velma Newell — Address: 821 Elkton Road, Newark, Delaware

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Compound, comminuted fracture skull

819 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Auto Accident auto - object by fire

20c. TIME OF INJURY: Hour: 8 p. m. — Month, Day: 1-6 — Year: 1959

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): M S 1

20f. (City or town): Conowingo (County): Harford (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer — Baltimore, Md. — DATE SIGNED: 1-7-59

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-10-59

22c. NAME OF CEMETERY OR CREMATORY: East Brookfield Cem.

22d. LOCATION (City, town, or county) (State): East Brookfield, Vermont

23. FUNERAL DIRECTOR'S SIGNATURE: William J Nanwick #1297 — ADDRESS: Newark, Del.

24a. REC'D BY REGISTRAR DATE: JAN 12 '59

24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

713

CERTIFICATE OF DEATH

00697

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
c. LENGTH OF STAY IN 1b: 40 yrs.,
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Edgewood
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Christina — Middle: — Last: Norris

4. DATE OF DEATH: Month: Jan. — Day: 21 — Year: 1959

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 31, 1889
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: none
11 BIRTHPLACE (State or foreign country): Joppa, Md.,
12. CITIZEN OF WHAT COUNTRY? U.S.A.,

13. FATHER'S NAME: Robert H. Lomyer
14 MOTHER'S MAIDEN NAME: Margaret Herbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no — none
16. SOCIAL SECURITY NO: none
17. INFORMANT Address: Charles A. Norris, Edgewood Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adeno Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO
1993
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 1956 to Jan. 21 1959 that I last saw the deceased alive on Jan. 19 1959, and that death occurred at 8 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William A. Tyson M.D.
ADDRESS (Street, city or town, state): Kingsville, Md.
DATE SIGNED: Jan. 21, 1959
PHYSICIAN'S NAME (Type): William A. Tyson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 24, 1959
22c NAME OF CEMETERY OR CREMATORY: Trinity Lutheran
22d. LOCATION (City, town, or county) (State): Joppa, Harford, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Howard E. McKenna Jr.
ADDRESS: Abingdon, Md.,
24a REC'D BY REGISTRAR DATE: JAN 27 '59
24b. REGISTRAR'S SIGNATURE: Grace S. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00698

714 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Magnolia
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Magnolia
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First John — Middle T. — Last Oakley

4. DATE OF DEATH: Month Jan. — Day 3, — Year 19 59

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Mar.26, 1888
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stationary Engineer
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.,
11. BIRTHPLACE (State or foreign country): Magnolia, Md.,
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas B. Oakley
14. MOTHER'S MAIDEN NAME: Laura T. Crouse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 220-22-0650
17. INFORMANT — Address: Fredericka Oakley, Magnolia, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovasc. Disease
DUE TO (b): Congestive Heart Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Obstructive Emphysema
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/10, 19 58, to 1/2, 19 59, that I last saw the deceased alive on 1/2, 19 59, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Louis Kahan M.D.
ADDRESS (Street, city or town, state): Box 966 Edgewood, Md.
DATE SIGNED
TYPED NAME: E. Louis Kahan,
Edgewood, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan.6,1959
22c. NAME OF CEMETERY OR CREMATORY: Cokesbury Memorial
22d LOCATION (City, town, or county) (State): Abingdon, Harford, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard R. McComas Jr
ADDRESS: Abingdon, Maryland.
24a. REC'D BY REGISTRAR DATE: JAN 7 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kinard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

688 **CERTIFICATE OF DEATH** 00699

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b Lifetime
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 418 N. Freedom St.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
d. STREET ADDRESS 418 N. Freedom St.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Sarah Middle Last Raco

4. DATE OF DEATH Month 1 Day 24 Year 1959

5. SEX Female

6. COLOR OR RACE Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8 DATE OF BIRTH 9-24-1874

9 AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10b KIND OF BUSINESS OR INDUSTRY Private Family

11. BIRTHPLACE (State or foreign country) Aberdeen Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME ? Taylor

14. MOTHER'S MAIDEN NAME Harriett French

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) —

16 SOCIAL SECURITY NO. 215-12-1032

17. INFORMANT Address 560 Girard St.
Mr. Lloyd Raco, Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)

DUE TO (c) Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 20, 1959, to Jan. 23, 1959, that I last saw the deceased alive on Jan 23, 1959, and that death occurred at 7:30 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE George T. Stansbury, M.D. ADDRESS (Street, city or town, state) 569 Revolution St., Havre de Grace, Md. DATE SIGNED 1/26/59

PHYSICIAN'S NAME (Type) George T. Stansbury

22a BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 1-27-59

22c NAME OF CEMETERY OR CREMATORY St James A. M. E. Cemetery

22d LOCATION (City town, or county) (State) Havre de Grace Md.

23 FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bullock ADDRESS Havre de Grace

24a. RECD BY REGISTRAR DATE JAN 29 '59

24b REGISTRAR'S SIGNATURE C. T. T. S. Tuttle

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

689

CERTIFICATE OF DEATH

00760

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b 10 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Md b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First Mary Middle Lena Last Phelps

4. DATE OF DEATH Month Jan Day 6 Year 19 59

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov 1 1882
9. AGE (In years last birthday) 76 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Thomas Howard Pabst
14. MOTHER'S MAIDEN NAME Mary Kurtsinger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Florence Rogers Haught Address Forest Hill Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardiovascular Disease
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH (a) days ? (b) years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Terminal bronchial pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 4th 19 59, to Jan 7th 19 59, that I last saw the deceased alive on Jan 4th 19 59 and that death occurred at 10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Edward C. Lee, M.D. ADDRESS (Street, city or town, state) 211 N. Union Ave. DATE SIGNED 1/9/59

PHYSICIAN'S NAME (Type) Edward C. Lee, M.D. Havre de Grace Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Jan 12, 1959
22c. NAME OF CEMETERY OR CREMATORY Old Brick Baptist
22d. LOCATION (City, town, or county) (State) Darlington Harford Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mia Van Eckhart Jarrettsville Md
24a. REC'D BY REGISTRAR DATE JAN 15 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, one ■ should ■ detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

715 CERTIFICATE OF DEATH

Reg. Dist. No. 00701

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Perryman
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Perryman
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CARRIE — Middle JANE — Last COLLINS PINION
4. DATE OF DEATH: Month January — Day 25 — Year 1959
5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/1/1866
9. AGE (In years last birthday): 92 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Leven Collins
14. MOTHER'S MAIDEN NAME: [illegible] Mary Welsh
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: George H. Pinion, Address: Perryman, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c): Hypertensive-Arteriosclerotic Heart disease
.43X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 7/28, 1956, to 1/25, 1959, that I last saw the deceased alive on 1/23, 1959, and that death occurred at 12:30 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: George T. Stansbury, M.D. — ADDRESS (Street, city or town, state): 569 Revolution St. — DATE SIGNED: 1/28/59
PHYSICIAN'S NAME (Type): Geogge T. Stansbury — Havre de Grace, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/29/59
22c. NAME OF CEMETERY OR CREMATORY: Union M.E. Cemetery
22d. LOCATION (City, town, or county) (State): R.D. Aberdeen, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE: John F. Barnes — ADDRESS: Aberdeen, Md.
24a. REC'D BY REGISTRAR DATE: JAN 29 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

716

CERTIFICATE OF DEATH

00702

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Bel Air/Aberdeen Road.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchville
d. STREET ADDRESS: Bel Air/Aberdeen Road.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Flora; Middle: A.; Last: Plummer

4. DATE OF DEATH: Month: 1; Day: 12; Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10/15/1869

9. AGE (In years last birthday): 89 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nelson Anderson

14. MOTHER'S MAIDEN NAME: Rachel Garrett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: None

17. INFORMANT: Piscero Plummer — Address: Aberdeen Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Generalized Arterio Sclerosis — 6 Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JAN 1, 1958, to JAN 12, 1959, that I last saw the deceased alive on JAN 8, 1959, and that death occurred at 11 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: André Weiss M.D — ADDRESS (Street, city or town, state): 114 W. Bel Air Av. Aberdeen, Md — DATE SIGNED

PHYSICIAN'S NAME (Type): ANDRE WEISS, MD. — 114 W. Bel Air Ave. 12 January 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/14/1959

22c. NAME OF CEMETERY OR CREMATORY: Churchville Presbyterian

22d. LOCATION (City, town, or county) (State): Churchville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring — ADDRESS: Tarring Funeral Home, Aberdeen Maryland

24a. RECORD OF REGISTRAR — DATE: JAN 19 '59

24b. REGISTRAR'S SIGNATURE: Clifton S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00703

717 **CERTIFICATE OF DEATH** Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Bel Air
c. LENGTH OF STAY IN 1b: 26 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford County Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Bel Air Rural — Harford County Home
d. STREET ADDRESS: Toll Gate Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Daniel Middle: Last: Prigg
4. DATE OF DEATH: Month: January Day: 29, Year: 1959
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: March 6, 1914
9. AGE (In years last birthday): 44 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Daniel Prigg
14. MOTHER'S MAIDEN NAME: Elizabeth Boadly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. Clark E Fitzpatrick, Address: Harford Co Home Toll Gate Rd., Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 8 days
490 x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-26, 1959, to 1-29, 1959, that I last saw the deceased alive on 1-26, 1959, and that death occurred at 3 P M, from the causes and on the date stated above.
ACTUAL SIGNATURE: Gerald E Palmer M.D. ADDRESS (Street, city or town, state): Bel Air, Md DATE SIGNED: 1-30-59
PHYSICIAN'S NAME (Type): Gerald E Palmer MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 30, 1959
22c. NAME OF CEMETERY OR CREMATORY: Harford County Home Cemetery
22d. LOCATION (City, town, or county) (State): Bel Air R.D., Harford Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster ADDRESS: W. Broadway & Williams St. Bel Air, Maryland
24a. REC'D BY REGISTRAR DATE: FEB 2 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

690

CERTIFICATE OF DEATH

Reg. Dist. No. 00704

1 PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace Md — c. LENGTH OF STAY IN 1b 15 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
d. STREET ADDRESS 417 Lodge — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First James — Middle Peter — Last Ruomony
4. DATE OF DEATH Month 1 — Day 5 — Year 59
5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 6/25/1905
9. AGE (In years last birthday) 53 yrs — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Common Handler
10b. KIND OF BUSINESS OR INDUSTRY Aberdeen Proving Ground
11. BIRTHPLACE (State or foreign country) York Pa
12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Valentine Ruomony
14. MOTHER'S MAIDEN NAME Hanna F. Miller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Martha M. Ruomony — Address 417 Lodge Havre de Grace Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
332x
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c) Cerebral Arteriosclerosis
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month — Day — Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/27 19 58 to 1/4 19 59 that I last saw the deceased alive on 1/4 19 59, and that death occurred at 9:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE George T. Stansbury M.D. — ADDRESS (Street, city or town, state) 529 Revolution St., Havre de Grace, Md. — DATE SIGNED 1/7/59
PHYSICIAN'S NAME (Type) George T. Stansbury

22a. BURIAL, CREMATION, REMOVAL (Specify) — 22b. DATE THEREOF 1/8/1959 — 22c. NAME OF CEMETERY OR CREMATORY Cokesbury — 22d. LOCATION (City, town, or county) (State) Bel Air Md.

23. FUNERAL DIRECTOR'S SIGNATURE Cunningham & Son — ADDRESS Havre de Grace Md.

24a. REC'D BY REGISTRAR DATE JAN 9 '59 — 24b. REGISTRAR'S SIGNATURE Catherine L. Hinds

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Claim 228 2-13-59 et

718 CERTIFICATE OF DEATH

Reg. Dist. No. 00705 52

1. PLACE OF DEATH a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel-Air Rural
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Valley Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Md. b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bush Rural Route 1 Box 44
d. STREET ADDRESS c/o George Anderson
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Rose Middle Reichert Last
4. DATE OF DEATH Month Jan. Day 25 Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 1867
9. AGE (In years last birthday) 92 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework at Home
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Unknown
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. No
17. INFORMANT Address Valley Nursing Home

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Dis- — INTERVAL BETWEEN ONSET AND DEATH 11 yrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/11, 19 59 to 1/25, 1959, that I last saw the deceased alive on 1/23, 1959, and that death occurred at M, from the causes and on the date stated above.
ACTUAL SIGNATURE Clifford F. Hudson M.D. ADDRESS (Street, city or town, state) Fork, Md. DATE SIGNED
PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON FORK MD.

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF Jan 31 1959
22c. NAME OF CEMETERY OR CREMATORY Blenheim
22d. LOCATION (City, town, or county) (State) Baltimore Md

23. FUNERAL DIRECTOR'S SIGNATURE H. A. Bailey ADDRESS Harlington Md
24a. REC'D BY REGISTRAR DATE FEB 5 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00706

718 CERTIFICATE OF DEATH

Reg. Dist. No. .....

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural—Bel Air

LENGTH OF STAY (In this place): 20 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural — Bel Air

STREET ADDRESS (If rural give location): Gibson

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Nannie	Leva	Rhodes	January 1 19 59

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	January 15, 1893	65 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		North Carolina	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Floyd Wood	Deame J. Baldwin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		Thomas E. Rhodes, Forest Hill, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Acute pulmonary edema, terminating a — INTERVAL BETWEEN ONSET AND DEATH: 15 minutes

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Disease Chronic cardio-vascular with hypertension and — 5 years

DUE TO (C) Chronic decompensation.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED White at work ☐ Not white at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. ....., 19 53 ....., to Jan. 1 ....., 19 59 ....., that I last saw the deceased alive on Dec. 31 ....., 19 58 ....., and that death occurred at 10:00 M, from the causes and on the date stated above.

SIGNATURE: Willard P. Hudson M.D. — ADDRESS (Street, city, town, state): Forest Hill, Md. — DATE SIGNED: January 2, '59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/3/59	Oak Grove Baptist	Bel Air, Maryland

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE JAN 5 '59		Joseph T. Tate	Bel Air Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

691 CERTIFICATE OF DEATH

00707
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Havre de Grace
d. STREET ADDRESS 213 N. Stokes Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Clarence Middle Last Richardson

4. DATE OF DEATH Month January Day 27 Year 1959

5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑
8. DATE OF BIRTH April 5, 1892
9. AGE (In years last birthday) 66 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber
10b. KIND OF BUSINESS OR INDUSTRY Self-Employed
11. BIRTHPLACE (State or foreign country) Havre de Grace, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Richardson
14. MOTHER'S MAIDEN NAME Francis Sheridan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO —
17. INFORMANT Address Mr. Eugene Richardson 565 S. St Clair St Havre de Grace

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Congestive Heart Failure	
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Diabetes Mellitus	
DUE TO (c)	Hypertensive-Arteriosclerotic Heart disease	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/10 19 58, to 1/27 19 59, that I last saw the deceased alive on 1/27 19 59, and that death occurred at 12:00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE George T. Stansbury, M.D. ADDRESS (Street, city or town, state) 569 Revolution St. Havre de Grace, Md. DATE SIGNED 1/27/59

PHYSICIAN'S NAME (Type) George T. Stansbury

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1/31/59
22c. NAME OF CEMETERY OR CREMATORY St. James Cemetery
22d. LOCATION (City, town, or county) (State) Havre de Grace Md

23. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bullock ADDRESS Havre de Grace, Md
24a. REC'D BY REGISTRAR DATE FEB 3 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [redacted] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

692 CERTIFICATE OF DEATH

Reg. Dist. No. 11768

1. PLACE OF DEATH a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace.
c. LENGTH OF STAY IN 1b Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Res. before admission) a. STATE Md. — b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
d. STREET ADDRESS 734 Otsego St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Olivia Middle Lost Richardson
4. DATE OF DEATH Month January Day 7 Year 1959
5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 7-12-1893
9. AGE (In years last birthday) 65 yrs
IF UNDER 1 YEAR Months 5 Days 25
IF UNDER 24 HRS Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY Chesapeake Hotel
11. BIRTHPLACE (State or foreign country) Harford County, Md
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Lloyd Richardson
14. MOTHER'S MAIDEN NAME Elizabeth Bowser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16 SOCIAL SECURITY NO
17. INFORMANT Address Mrs. Lewis V. Richardson - Havre de Grace, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c) Hypertensive-Arteriosclerotic Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/10, 1958 to 1/6, 1959, that I last saw the deceased alive on 1/6, 1959, and that death occurred at 2:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE George T. Stansbury, M.D. ADDRESS (Street, city or town, state) 528 Revolution St. Havre de Grace, Md. DATE SIGNED 1/7/59
PHYSICIAN'S NAME (Type) George T. Stansbury

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1-10-59
22c. NAME OF CEMETERY OR CREMATORY St James Cemetery
22d LOCATION (City, town, or county) (State) Havre de Grace, Md

23. FUNERAL DIRECTOR'S SIGNATURE Elmer E Bullock
ADDRESS Havre de Grace, Md
24a REC'D BY REGISTRAR DATE JAN 13 '59
24b. REGISTRAR'S SIGNATURE Cullen L. Knotts

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

693

CERTIFICATE OF DEATH

00709

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace

c. LENGTH OF STAY IN 1b: 19 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md — b. COUNTY Harford

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen

d STREET ADDRESS: RD # 1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Gertrude — Middle — Last Sampson

4. DATE OF DEATH: Month January — Day 30 — Year 1959

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 6 1911

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Md Harford Co

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: Lewis Denham

14. MOTHER'S MAIDEN NAME: Annie L. Mitchell

15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 216-05-3169

17. INFORMANT: Geo. Sampson — Address: P.O. Box 186 Forest Hill Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Status epilipticus (convulsion) — INTERVAL BETWEEN ONSET AND DEATH: 0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Portal cirrhosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on January 30, 1959, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James McC. Finney M.D. — ADDRESS (Street, city or town, state): 330 S. Union Ave, Havre de Grace, Md. — DATE SIGNED: 1-31-59

PHYSICIAN'S NAME (Type)

22a BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Feb 2 1959 — 22c. NAME OF CEMETERY OR CREMATORY: Rock Run Cem — 22d LOCATION (City, town, or county) (State): Harford Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. S. Bailey — ADDRESS: Darlington Md.

24a. REC'D BY REGISTRAR DATE: FEB 4 '59 — 24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

720 CERTIFICATE OF DEATH

Reg. Dist. No. 00714

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
c. LENGTH OF STAY IN 1b: 14 yrs.,
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Joppa
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Anderson — Last: Seaman

4. DATE OF DEATH: Month: Jan. — Day: 13, — Year: 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 5, 1894

9. AGE (In years last birthday): 64 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Motorman

10b. KIND OF BUSINESS OR INDUSTRY: Transportation

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: Charles T. Seaman

14. MOTHER'S MAIDEN NAME: Laura Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
If yes, give war or dates of service: WW 1

16. SOCIAL SECURITY NO.: 215-09-3632

17. INFORMANT: Mrs. Barbara W. Seaman, Address: Joppa, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Transverse Colon — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/1, 1958, to 1/13, 1959, that I last saw the deceased alive on 1/13, 1959, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

SIGNATURE: E. Louis Kahan M.D. ADDRESS (Street, city or town, state): Box 966 Edgewood, Md. DATE SIGNED

PHYSICIAN'S NAME (Type): Louis. E. Kahan Edgewood, Maryland,

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan.15,1959

22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

22d. LOCATION (City, town, or county) (State): Bel Air, Harford, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard R. McComas Jr ADDRESS: Abingdon, Md.,

24a. REC'D BY REGISTRAR DATE: JAN 16 '59

24b. REGISTRAR'S SIGNATURE: C. Thos S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 would be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

694 CERTIFICATE OF DEATH

Reg. Dist. No. 00711

1. PLACE OF DEATH
a. COUNTY: HARFORD — STATE: Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 656 Franklin
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: IDA — Middle: ARMOR — Last: SENTMAN

4. DATE OF DEATH: Month: JANUARY — Day: 14 — Year: 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/24/1878

9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Wife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE FREDERICK ARMOR

14. MOTHER'S MAIDEN NAME: JENNY DICKEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Mrs. Cuma Sentman — Address: 656 Franklin St. Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b): Arteriosclerosis - Hypertension
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour, o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/7 1956 to 1/14 1959, that I last saw the deceased alive on 1/14 1959, and that death occurred at 1:50 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: C. L. Lewis M.D. — ADDRESS (Street, city or town, state): Havre de Grace Md. — DATE SIGNED: 1-16-59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 1/17/59 — 22c. NAME OF CEMETERY OR CREMATORY: Angel Hill — 22d. LOCATION (City, town or county) (State): Havre de Grace Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Emmert & Son — ADDRESS: Havre de Grace Md.

24a. REC'D BY REGISTRAR DATE: JAN 20 '59 — 24b. REGISTRAR'S SIGNATURE: C. Lewis Price

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be affixed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

721 CERTIFICATE OF DEATH

Reg. Dist. No. 00712

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
c. LENGTH OF STAY IN 1b: 7 yrs.,
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Joppa
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: O. — Last: Sparks

4. DATE OF DEATH: Month: Jan. — Day: 17 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July, 15, 1882

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Owner

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: William Sparks

14. MOTHER'S MAIDEN NAME: Mary Moxley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Mrs. Clittis Moxley, Joppa, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cerebrovascular and
DUE TO (b): Cardiovascular Disease
DUE TO (c): C.V.A.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
422.1
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/7, 19 59, to 1/16, 19 59, that I last saw the deceased alive on 1/16, 19 59, and that death occurred at 4:00 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E Louis Kahan M.D. — ADDRESS (Street, city or town, state): Box 96 Edgewood, Md — DATE SIGNED

PHYSICIAN'S NAME (Type): E. Louis Kahan — Edgewood, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 1/18/1959
22c. NAME OF CEMETERY OR CREMATORY: Moody Funeral Home
22d. LOCATION (City, town, or county) (State): Mount Airy, Surry, N.C.,

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K McCormick Jr — ADDRESS: Abingdon, Maryland

24a. REC'D BY REGISTRAR DATE: JAN 20 '59

24b. REGISTRAR'S SIGNATURE: Clinton S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

722

CERTIFICATE OF DEATH

Reg. Dist. No. 00713

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 1 Liberty Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MORTON Middle PAUL Last TAYLOR

4. DATE OF DEATH: Month January Day 12 Year 1959

5. SEX: Male

6. COLOR OR RACE: Negroid

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 11, 1959

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months — Days 2 — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Ulysses Morton Taylor

14. MOTHER'S MAIDEN NAME: Elisabeth Waltrudis Renz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT Address: ~~Morton~~ Ulysses M. Taylor, 1 Liberty, Aberdeen, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apnea Neonatorum — INTERVAL BETWEEN ONSET AND DEATH

771.0

DUE TO (b) Cerebral Hemorrhage

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Hemorrhagic Disease of Newborn, Prematurity

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 11, 1959, to January 12, 1959, that I last saw the deceased alive on January 12, 1959, and that death occurred at 9:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas J Fraher M.D

ADDRESS (Street, city or town, state): US Army Hosp, Aberdeen Proving Gnd.

DATE SIGNED: Jan 12, 59

PHYSICIAN'S NAME (Type): THOMAS J. FRAHER, Capt, MC

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 1-15-59

22c NAME OF CEMETERY OR CREMATORY: U.S. Government Cemetery

22d LOCATION (City town, or county) (State): Aberdeen Proving Ground Md

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Otelia D Bullock, Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: JAN 19 '59

24b REGISTRAR'S SIGNATURE: Ivan S. Kirwan

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, .

695

CERTIFICATE OF DEATH

00714

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY HARFORD MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE
c. LENGTH OF STAY IN 1b LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 801 ONTARIO, ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE
d. STREET ADDRESS 801 ONTARIO ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First KATHERINE Middle FRANCES Last WERNER
4. DATE OF DEATH Month JAN. Day 11 Year 1959
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH MAR. 26, 1874
9. AGE (In years last birthday) 84 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK
10b. KIND OF BUSINESS OR INDUSTRY HOME
11. BIRTHPLACE (State or foreign country) MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JOHN WERNER SR.
14. MOTHER'S MAIDEN NAME REGINA SITZLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Address Mrs. A. HUGHES SPENCER, HAVRE DE GRACE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular disease — INTERVAL BETWEEN ONSET AND DEATH
422.1
DUE TO (b) Cardiac Insufficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/12 ——, 19 48 to JAN. 11 ——, 19 59 that I last saw the deceased alive on Jan 10 ——, 19 59, and that death occurred at 3 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE [signature] M.D.
ADDRESS (Street, city or town, state) [illegible]
DATE SIGNED 1/14/59
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 1-13-1959
22c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMI.
22d. LOCATION (City, town, or county) HAVRE DE GRACE (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE [signature] ADDRESS HAVRE DE GRACE MD
24a. REC'D BY REGISTRAR DATE JAN 14 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

723

CERTIFICATE OF DEATH

00715

Reg. Dist. No. .....

1. PLACE OF DEATH

COUNTY Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocks

LENGTH OF STAY (in this place) 61 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS Route #24

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rocks

STREET ADDRESS (If rural give location) Route #24

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	Clarence	Wilson	Jan.	8,	1959

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Widowed	Sept. 20, 1874	84 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming	Farmer	Maryland	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel Wilson	Mary McAlister

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	—	None	Frances W. Hince, Rocks, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
44.9 IMMEDIATE CAUSE	(A)	Malnutrition and Pulmonary Edema	2 wks
ANTECEDENT CAUSE(S) DUE TO	(B)	Senile Psychosis	6 to 8 mos
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	(C)	Hypertensive Arteric Sclerotic Cardio-Vascular Disease	over 10 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 57, to Jan 8, 59, that I last saw the deceased alive on Jan 7, 1959, and that death occurred at 6:50 P.M., from the causes and on the date stated above.

SIGNATURE Philip W. Hinman M. D. **ADDRESS** (Street, city, town, state) **DATE SIGNED**

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 10, 1959	Holy Cross Episcopal Cemetery	Rocks, Harford Co., Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
JAN 12 '59	Arthur S. Krause	Joseph W. Foster	W. Broadway & Williams St. Bel Air, Maryland